Highland
Musculo-Skeletal
Associates, Inc.

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RE: Thelma Peoples
Claim No. 914976-22

Bear Mr. Spector:

I evaluated the above claimant in my office on November 21, 1996, in reference to her continuing right shoulder pain. A medical history was taken of both the 1986 and 1989 injuries while employed by TRW. In the first job she was a packer and then her last job with TRW was a grinder.

The original injury to her right shoulder was on May 7, 1986. The claimant tripped on a leg of a picnic table and apparently injured her shoulder in the form of a strain or sprain, trying to stop her fall. She was treated by an orthopaedic surgeon, Dr. Curtis Smith, who after diagnostic work-up, described a sprain of the right shoulder. The original claim was recognized as a sprain. There was no mention of previous osteoarthritis of the acromioclavicular joint and absolutely no mention of suspicious symptoms that would raise one's suspicion for a tear of the rotator cuff. She was out of work for a period of time, approximately six weeks, and then she continued to work without restrictions until the 1989 incident.

On February 9, 1989 she slipped and fell, and reinjured the right shoulder, as well as her low back (Claim No. L3681-22). She subsequently came under the care of Dr. Vangelos who, after appropriate diagnostic workup, discovered a tear of the rotator

cuff. This was not formerly diagnosed until an arthrogram was performed on May 30, 1990. The care that was documented in the early 1990's was not recalled by the claimant in her medical history. There appears to be two entirely separate incidences, the 1986 which she subjectively recovered from and the 1989 reinjury to the shoulder.

Subsequently she came under the care of Dr. Mark Schickendantz who initially evaluated her on October 13, 1993. She presented a history of initially being seen at the Kaiser Emergency Room, having a contusion which was followed by a series of injections during the four years after the right shoulder was injured in 1989. Of particular interest throughout all of this history was that there was absolutely no mention of the lipoma along the anterior lateral aspect of her right shoulder.

Ultimately on November 9, 1993, an MRI scan was performed of the right shoulder. This confirmed a rather large, full thickness, rotator cuff which measured 2-1/2 x 2-1/2 cm. Of special notation was the fact that there was rather severe impingement primarily due to pre-existing acromioclavicular arthritis and a very large spur was present as well. It was therefore well documented that in addition to the rotator cuff tear, which may have been related to the 1989 injury, there was a rather large spur with degenerative arthritis of the acromioclavicular joint.

Ultimately she did undergo a surgical repair of the right rotator cuff. As part of the procedure an acromioplasty was performed. That is, spurs were actually removed from the undersurface of the clavicle and acromion process of the scapula for visualization purposes. The rotator cuff was repaired. There was no mention up to this point of the lipoma. If, in fact, this was present prior to the surgery, it is unknown why the lipoma was not removed. The lipoma is, of course, a benign fatty tumor that is not related to traumatic incident. Dr. Schickendantz described the complex repair of the rotator cuff. Pathology specimens from the Lutheran Medical Center show fragments of synovial tissue, cartilage, and bone chips which were consistent with the surgical debridement during the rotator cuff surgery.

Postoperatively the claimant went through a fair amount of physical therapy but did not achieve complete range of motion or functional use of the upper extremity. She is

unaware of what the doctors' thoughts were in her lack of progress. She began having more and more pain in the latter months of 1994 and 1995, and early 1996. The pain was diffusely localized in the anterior shoulder region in the right acromioclavicular joint, as well as in this subcutaneous lipoma. There was some notation in the medical records that this, in fact, was enlarging and was a source of pain. Surgery was recommended to remove the lipoma and to excise the right acromioclavicularjoint.

CURRENT SYMPTOMS: At the time of this evaluation the claimant still continues to have diffuse right shoulder pain. This is poorly localized. There is pain in the area of the lipoma, as well as diffusely in the anterior deltoid, anterior chest, and supralateral aspect of the shoulder as well. She has difficulty raising her ann above the shoulder level. Lifting, carrying and repetitive lifting seems to bother her. She cannot position hex- arm in internal rotation and there has been some loss in her mobility across her chest reaching toward her left shoulder as well.

CURRENT SYMPTOMS: She is an insulin dependent diabetic and takes Motrin and Ultram for control of her pain, both in her low back and her right shoulder.

PHYSICAL EXAMINATION revealed a pleasant 64 year old female who appeared in some distress. She had some difficulty arising from a sitting position, as well as ascending and descending the examining table. This was primarily due to her low back complaints.

Specific examination of her right shoulder revealed a well-healed scar compatible with her surgical history. There was a well defined multi loculated lipoma which was just lateral to the anterior surgical incision. Virtually every area that was touched was painful to palpation. Particularly the anterior acromial arch and the acromioclavicular joint was very painful.

Range of motion of the shoulder was also limited to approximately 95 degrees of forward flexion, 85 degrees of abduction, only 10 degrees of internal rotation, and approximately 30 degrees of external rotation. There was some diffuse muscle wasting in the deltoid region on the right side. Circumferential measurements showed

approximately 1-1/2 cm of atrophy. The elbows, wrists and small joints of the hand examined normally. Neurologic examination was normal.

IMPRESSION: 1) Resolved sprain of the right shoulder (1986 injury). 2) Re-sprain of the right shoulder with rotator cuff tear (1989 injury). **Unrelated** lipoma of the anterior right shoulder and acromioclavicular degenerative arthritis.

DISCUSSION: I have had the opportunity to review some medical records associated with her care and treatment. These include records from the Industrial Commission of Ohio, Dr. Mark Schickendantz, Dr. Vangelos, Lutheran Medical Center, The Steffee Orthopaedic MRI report, as well as an evaluation by Dr. Fierra and Dr. Gustafson.

Mer careful questioning of the patient's history and physical limitations, as well as after a careful physical examination and review of medical records, I have come to some conclusions concerning her ongoing level of physical impairment.

To specifically address the questions proposed, it is my opinion, within a reasonable degree of medical certainty, that the acromioclavicular joint arthritis is **degenerative** and not traumatic in nature. There was absolutely no mention in the medical records of any strain or sprain to the acromioclavicular joint. This sprain was to the "shoulder." There was never a statement that the degenerative arthritis was caused, aggravated or accelerated by either of the two injuries. There was absolutely no mention of the lipoma until a substantial period of time had past **after** the surgical procedure.

The operative note again does not mention the lipoma whatsoever. It clearly describes rather advanced prolific hypertrophic arthritis of the acromioclavicular joint. This was not related to any trauma, but due to a progressive degenerative condition. It was not noted in the medical records why the acromioclavicular joint was not excised at the time of the rotator cuff surgery nor why the lipoma was not removed while the operation progressed. This would have added little morbidity to the procedure and would have handled both pre-existing unrelated medical conditions.

At the present time she is symptomatic just about everywhere one can touch. She clearly has well documented progressive arthritis of the degenerative nature in the acromioclavicular joint. The appropriate treatment for this would be surgical excision in the form of a Mumford Procedure. This would involve a resection of the distal clavicle and essentially is an arthroplasty which involves partial removal of the joint. This would certainly eliminate pain that was coming strictly from the arthritis. It is my opinion, within a reasonable degree of medical certainty, that this condition was a concomitant medical condition **unrelated** to either the 1986 or 1989 traumas.

The lipoma of the anterior shoulder was also tender to palpation. If this was to be excised, in my opinion, the excision would be **unrelated** to the rotator cuff tear. Lipomas are clearly not traumatic in origin. Neither the claimant nor the operating surgery has expressed in the medical records a direct cause and effect relationship. If one would proceed with a surgical procedure to remove the acromioclavicular joint, then it would add very little morbidity to remove the lipoma as well. This procedure; however, in my opinion, is unrelated to the claims in question and related solely to two concomitant medical conditions, that is degenerative arthritis and subcutaneous lipoma.

In my opinion, the decreased range of motion of the shoulder is strictly due to the postoperative adhesive capsulitis. The claim, in my opinion, is appropriate as stated: Sprain of the right shoulder, right rotator cuff tear and adhesive capsulitis. The osteoarthritis of the acromioclavicular joint, as stated above, as well as the lipoma, are unrelated concomitant medical conditions.

Sincerely,

Robert C. Corn, M.D., F.A.C.S.

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